DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacies
All Prescribers
Managed Care Plans
Nursing Home Administrators

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Memorandum No: 04-59 MAA
Issued: July 30, 2004

For More Information, call:
1-800-562-6188

Subject: Prescription Drug Program: Prior Authorization Changes

Effective the week of August 2, 2004, **and after**, the Medical Assistance Administration (MAA) will implement the following changes to the Prescription Drug Program:

- Expedited Prior Authorization Changes; and
- Additions to Expedited Prior Authorization Codes and Criteria.

Expedited Prior Authorization Changes

Drug	Code	Criteria
Adderall® *(Amphetamine/Dextroamphetamine)* **Dexedrine®, Dextrostat®** *(Dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.
Adderall XR® *(Amphetamine/Dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Total daily dose is administered as a **single dose.**

Expedited Prior Authorization Changes (cont.)

Drug	Code	Criteria
Concerta® *(Methylphenidate)* **Focalin**® *(Dexmehtylphenidate)* **Metadate CD**® *(Methylphenidate)* **Ritalin LA**® *(Methylphenidate)*	149	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Strattera® *(Atomoxetine HCl))*	007	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD).
Kytril® *(Granisetron)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.

Additions to Expedited Prior Authorization Codes and Criteria

Drug	Code	Criteria
Copegus® *(Ribavirin)* **Rebetol**® *(Ribavirin)* **Ribavirin**	010	Diagnosis of chronic hepatitis C virus infection and patient must also be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).

Attached are replacement pages H.7-H.14 which replace page H.7 through H.20 of MAA's Prescription Drug Program Billing Instructions, dated February 2003. To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the Billing Instructions/Numbered Memoranda link).

Drug	Code	Criteria
Abilify® *(Aripiprazole)*	015	All of the following must apply a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
Accutane® *(Isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**: a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
Adderall® *(Amphetamine/ Dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) of Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.
Adderall XR® *(Amphetamine/ Dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Total daily dose is administered as a single dose.
Adeks® **Multivitamins**	102	For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all the following: a) Patient is under medical supervision; and b) Patient is not taking oral anticoagulants; and c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

Drug	Code	Criteria
Aggrenox® *(Aspirin/ Dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Altace® *(Ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(Zolpidem tartrate)*	006	Short-term treatment of insomnia. Drug Therapy is limited to 10 in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotesin converting enzyme (ACE) inhibitor. **Atacand**® (Candesartan cilexetil) **Atacand HC**T® (Candesartan cilexetil/HCTZ) **Avalide**® (Irbesartan/HCTZ) **Avapro**® (Irbesartan) **Benicar**® (Olmesartan medoxomil) **Cozaar**® (Losartan potassium) **Diovan**® (Valsartan) **Diovan** HCT® (Valsartan/HCTZ)) **Hyzaar**® (Losartan potassium/HCTZ) **Micardis**® (Telmisartan) **Micardis HCT**® (Telmisartan/HCTZ) **Teveten**® (Eprosartan mesylate) **Teveten HCT**® (Eprosartan mesylate/HCTZ)
Anzemet® *(Dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.

Drug	Code	Criteria
Avinza® *(Morphine sulfate)*	040	Diagnosis of cancer-related pain.
Calcium w/Vitamin D	126	Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.
Clozapine Clozaril®	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(Methylphenidate)*	149	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Copegus® *(Ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection and patient must also be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Dexedrine® *(D-Amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *D-Amphetamine sulfate)*		See criteria for Adderall®.
Duragesic® *(Fentanyl)*	040	Diagnosis of cancer-related pain.
Focalin® *(Dexmethylphenidate)*		See criteria for Concerta®.

Drug	Code	Criteria
Goedon® *(Ziprasidon)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
☞		**Note:** Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infraction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Infergen® *(Interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(Morphine sulfate)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Kytril® *(Granisetron)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® *(Terbinafine)*		Treatment of onychomycosis for up to 12 months per nail is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulites secondary to onychomycosis and requiring systemic antibiotic therapy; or
	045	Fingernail involvement with or without chronic paronychia.
Levorphanol	040	Diagnosis of cancer-related pain.
Marinol® *(dronabinol)*	035	Diagnosis of cachexia associated with AIDS
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadata CD®		See criteria for Concerta®.
Miralax® *(Polyethylene glycol 3350)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Naltrexone		See criteria for ReVia®.

Drug	Code	Criteria
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(Ferrous Fumarate/ Folic acid)* **Nephro-Vite**® *Vitamin B Comp W-C)* **Nephro-Vite RX**® *(Folic acid/Vitamin B Comp W-C)* **Nephro-Vite+FE**® *(Fe Fumarate/FA/ Vitamin B Comp W-C)* **Nephron FA**® *(Fe fumerate/Doss/ FA/B Comp & C)*		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.
Ansaid® *(Flurbiprofen)* Arthrotec® *(Diclofenac/misoprostol)* Bextra® *(Valdecoxib)* Cataflam® *(diclogenac)* Celebrex® *(celecoxib)* Clinoril® *(Sulindac)* Daypro® *(Oxaprozin)* Feldene® *(Piroxicam)* Ibuprofen Indomethacin Lodine®, Lodine XL® *(Etodolac)* Meclofenamate Mobic® *(Meloxicam)* Nalfon® *(Fenoprofen)* Naprelan®, Naprosyn® *(Naproxen)* Orudis®, Oruvail® (*Ketoprofen*) Ponstel® *(Mefenamic acid)* Relafen® *(Nabumetone)* Tolectin® *(Tolmetin)* Toradol® *(Ketorolac)* Vioxx® *(roefecoxib)* Voltaren® *(Diclofenac)*		
Oxandrin® *(Oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.

Drug	Code	Criteria
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(Oxycodone HCI)*	040	Diagnosis of cancer-related pain.
PEG-I*ntron*® *(Peginterferon Alpha 2b)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Pegasys® *(Peginterferon Alpha-2a)*	109	Treatment of chronic hepatitis C patients 18 years of age or older.
Plavix® *(Clopidogrel bisulfate)*	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.
Pravachol® *(Pravastatin)*	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Pulmozyme® *(Deoxyribonuclease)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Rebetol® *(ribavirin)*	010	See criteria for Copegus.

Drug	Code	Criteria
Rebetron® *(Ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Rena-Vite® **Rena-Vite RX**® *(Folic Acid/Vit B Comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(Naltrexone)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
Ribavirin	010	See criteria for Copegus®.
Risperdal® *(Risperidone)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.

☞ **Note:** A Revia (Naltrexone) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html

Drug	Code	Criteria
Ritalin LA®		See criteria for Concerta®.
Roferon-A® *(Interferon alpha-2b) recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age and older.
Seroquel® *(Quetiapine fumarate)*	054	See criteria for Risperdal®.
Sonata® *(Zaleplon)*		See criteria for Ambien®.
Soriatane® *(Acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.

Drug	Code	Criteria
Sporanox® *(Itraconazole)*		Must not be used for a client with cardiac dysfunction such as congestive heart failure.
	047	Use for patients with systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulites secondary to onychomycosis **and** requiring systemic antibiotic therapy; or
	045	Fingernail involvement with or without chronic paronychia.
Strattera® *(Atomoxetine HCI)*	007	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD).
Suboxone® *(Buprenorphine/Naloxone)*	019	Before this code is allowed, the patient must meet <u>all</u> of the following criteria. The patient: a) Is **16** years of age or older; b) Has a <u>DSM-IV-TR</u> diagnosis of opioid dependence; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, Phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified chemical dependency treatment program. **Limitations:** • No more than 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. <u>The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;</u> • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization.
		☞ **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** **http://www1.dshs.wa.gov/msa/forms/eforms.html**
Symbyax® *(Olanzapine/ Fluoxetine)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated bipolar disorder; and b) Patient is **6** years of age or older.

Drug	Code	Criteria
Talacen® *(Pentazocine/ acetaminophen)* **Talwin NX**® *(Pentazocine)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Toprol XL® *(Metoprolol XL)*	041	Diagnosis of congestive heart failure.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin ADC Drops	093	The child is breastfeeding and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(Bupropion SR and XL)*	014	Treatment of depression.
Zofran® *(Odansetron)*		See criteria for Kytril®.
Zometa® *Zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® **Zyprexa Zydis**® *(Olanzapine)*	054	See criteria for Risperdal®.

Limitation Extensions

What is a Limitation Extension?

A Limitation Extension (LE) is a request to exceed stated limitations or other restrictions on covered services. LE is a form of prior authorization. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165. Providers must be able to verify that it is medically necessary to provide more units of prescription drugs than allowed in MAA's billing instructions and Washington Administration Code (WAC).

Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I get LE authorization?

Limitation extensions may be requested by calling MAA's Drug Utilization and Review at 1-800-848-2842.

Limitation Extensions DO NOT APPLY to noncovered prescription drugs.
See page C.4 for information on Exception to Rule.